The Gold Standards Framework - Acute Hospital Programme

Summary of Evidence of Effectiveness

National GSF Centre September 2016

Part 1 Summary

This summary of evidence describes the current evidence of effectiveness following the introduction of the Gold Standards Framework Acute Hospital (GSF AH) training and accreditation programmes since 2008. The GSFAH programme builds on the learning, experience and evaluations from the other GSF Programmes, notably those in Primary Care and Care Homes. It includes evidence from intrinsic GSFAH training programmes, findings from GSFAH Accredited wards and independent peer reviewed papers. This relates to three areas that GSF aims to improve:

1. **Quality of care** including patient experience of care
2. **Coordination and collaboration** within and between teams
3. **Patient outcomes** including more dying where they choose and reducing hospitalisation.

The summary of evidence is presented in a tabulated form for ease of reference showing findings from ward evaluations and accreditation results related to each statement. In addition a summary of available evidence from peer –reviewed published literature is provided.

The GSF Acute Hospital Programme demonstrates improvements in:-

1. **Quality of end of life care provided :**
   a) **Cultural change-** through transforming the culture and quality of care with sustainable long term improvements, encouraging an open approach to discussing end of life care.
   b) **Workforce** - developing staff confidence and supporting staff in planning and giving care
   c) **Patient Centred Care** - Helping patients live well until they die, and die well where they choose. Promoting more personalised care in line with person centred approach.
   d) **Proactive and anticipatory** - Facilitating proactive care and anticipatory care planning
   e) **Standards and governance** - Improving documentation , governance and communication with cross boundary teams and improving measurable standards of care.

2. **Coordination:**
   a) **Proactive early identification** of patients leading to earlier planning of care.
   b) **Team work and collaboration**, coordination within teams and across boundaries
   c) **Communication**- enable better team-working and information sharing; promoting collaborative working with GPs, District Nurses, Palliative Care and other specialists.
   d) More proactive support and coordination of care for carers.

3. **Outcomes:**
   a) **Improve personalised end of life care** -enabling more to live and die where they choose.
   b) **Reduction of hospitalisation** - fewer hospital deaths, fewer crisis and reduced length of stay in hospital.
   c) **Symptom control** - Improving effective assessment and management of symptoms, including anticipatory planning and management.

d) **Cost effectiveness** - Enabling cost effectiveness and cost savings for the NHS
e) **Sustainability** – embedding sustained long term changes in practice.

Background information on End of Life Care and GSF

About 50% of the population die in hospitals[1], 40-50% patients who die in hospitals could have died in the community with better support and training [2]and almost 30% of hospital patients are in their last year of life[3] . Despite the introduction of NICE Guidance in End of Life care [4]and Care for the Dying Adult[5] and the introduction of new approaches to care in the final days[6] , there are still serious inadequacies in care for patients dying in hospital.[7]

Improving End of Life Care is a priority and an ambition of the NHS [8]But how can such transformation happen on the ground and what evidence is there that systematic proactive care can improve patient experience of care, coordination and patient flow across boundaries of care, cost-effectiveness and outcomes?

The Gold Standards Framework (GSF) approach, training programmes and accreditation . GSF is a practical systematic evidence-based approach to optimising care for all people in any setting in the final years of life, focussing mainly on care given by generalist front-line staff. It aims to improves three things- the quality of care , coordination, and organisation of care and improve patient outcomes, enabling more to live and die in the place and the manner of their choosing .

GSF is well established in the community, developing in 2000 initially for primary care, for care homes in 2004 and hospitals 2008 and the GSF Centre is now the leading provider of training for generalist frontline staff in the UK.

With a population-based approach, including earlier identification of people in the last years of life, more advance care planning discussions and better proactive planning of personalised quality care ensures enables better care for more people- the right care for the right person at the right time in the right place every time (the 5 GSF Gold standards assessed at Accreditation)n . This proactive approach leads to fewer avoidable admissions and deaths in hospitals, more integrated cross boundary care and better use of limited resources at a time of decreasing funding.

Key message:. The Gold Standards Framework is a systematic evidence based programme which can contribute to achieving the proactive care necessary to improve patient experience and enable more to live and die where they choose .GSF enables the right care for the right person in the right place and at the right time, everytime

[1] NEOLC Intelligence Network, weblink)
[2] National Audit Office report 2008 weblink
[3] Clark et al., 2014 add ref .
[4] NICE Guidance on End of Life Care 2013
[5] NICE Guidance on Care for the Dying Adult 2015)
[6] More care less pathway date
[7] Royal College of Physicians Care of the Dying in Hospital Report 2016
[8] (NHS, 2014).

GSF provides evidenced based service improvement programmes (**quality improvement**) with high standards of ongoing support (**quality assurance**) and Accreditation that can be used to enhance the commissioning of services for all **quality recognition** outcomes.

The role of GSF was clearly identified in the End of Life Care Strategy which recommended that *"Every organisation involved in providing end of life care will be expected to adopt a coordination process such as the GSF"* (DOH, 2008). More recently the Care Quality Commission has recognised GSF Accreditation process is the only hospital information source approved by the CQC inspection process. Through implementation of GSF there has been a step-change in the quality of care for many thousands of people, and significant NHS cost-savings through reduced hospitalisation.

Key message: GSF enables identification and coding of patients facilitating appropriate assessment and planning of current and future needs

Outcome measurement

Key message: GSF has an established set of outcome measures and evaluation metrics which demonstrate improvement in quality of care, coordination and reduced hospitalisation.

Measurement of EOL quality of care is challenging, but essential. Over time, GSF has established a unique set of key outcome ratios, audit and feedback for evaluation, which fit around the NHS Outcomes Framework[14], NHS England Actions for EOL Care (2014), Social Care Policy and NICE Quality Standard for End of Life Care Standards (2011). Quality improvements, such as staff confidence, patient and carer experience are further evaluated through case studies based on feedback from participants. These give insight into the qualitative outcomes of participation in a GSF programme. These established metrics of measurement enable GSF programmes to collate cumulated evidence demonstrating the achievements and benefits of participation and to continue to evolve.

Table 1 Summary of the AH GSF Programme

GSF Hospital Training 3 step programme	GSF Centre provision of support for hospitals doing GSFAH programme	Local hospital suggested teaching of GSFAH via local facilitators	Intrinsic and extrinsic GSF Evaluations
Identify • Early Identification of the 30% patients • Needs based coding and need Support matrixes/ Core Care Plans • MDT discussions **Assess**	• 2 year programme plan with key milestones leading to Foundation Level at Year 1 and Enhanced at Year 2, and on to accreditation • 6 interactive small group train the trainers workshops	**General** • awareness of hospital teams • induction, all staff **On ward** • ward round, group or one to one teaching ,	Baseline and follow up • Key Outcome Ratios • Organisational questionnaires • Staff Survey • After Death Analysis / After Discharge Analysis

• Clinical Assessment • Personal-Advance care Planning ACP discussions (3 levels) • Assess Carers needs **Plan** • Plan Living well- improve cross boundary care • Dying Well- care in final days- After Death Care and bereavement	• Resources include flowcharts, mini-PIG prompts, guidance, animated videos • Individual coaching support for local facilitators • Measurement for formative and summative evaluations	**Specific teaching sessions** • Doctors AHPs nurses etc in focussed teaching • Induction • Update all staff	ADA • Qualitative feedback from staff • Independent analysis for hospital reports after 22 years • Further analysis for Accreditation and approval by independent panel

Table 2 Summary of findings from hospital wards involved in GSF training (comparative ICF GHK evaluations 3 reports) and accreditation (GSF AH Accreditation data collection) .

	Area of improvement	**A. Wards in training – Findings from ICF GHK reports 1,[i]2,[ii]3 [iii]of wards in training in 26 hospital wards**	**B. GSF Accredited wards Findings from first 8 GSF Accreditation wards following GSF evaluations , portfolio and assessment visit [iv]**
1.	Staff confidence, awareness and culture change	Staff survey indicates an increase in staff confidence and knowledge of EoLC, particularly communication skills and symptom management.3	Awareness and confidence improved in staff surveys and in Interviews with staff on accreditation Visits
2.	Early identification of patients in the last year of life	Increased use of processes to identify patients in last year of life 1. "*The identification of patients nearing the end of life improved greatly between baseline and follow up*" p26 3	Average 32% see Fig 1
3.	More advance care planning and DNAR recorded	DNACPR recording increases with up to 100% recording of DNAR status following GSF training 3	Average 95% offered ACP Level 1 discussion, 77% offered Level 2, 34% Level 3 full ACP discussion. See Fig 2
4.	Reduced length of stay	Length of stay declines following GSF training by an average of 4.4 days. 1,2,3	Not assessed
5.	Improved rapid discharge processes	More patients are discharged on a rapid discharge pathway 1	More effective discharge planning to facilitate preferred place of care
6.	Improved communication and coordination with GP and community	Improved communication and coordination between those delivering EoL Care. "*The discharge summary has improved communication medic to GP and ward nurse to DN.*" Phase 3 AFGSF Staff questionnaire 2	Improved discharge communication to GPs to include 3 key areas of recommendation to include on their GSF register, coding and ACP discussion progress.
7.	Carer support	Discussions with carers increase, for some wards an increase of 20% was observed 1	Assessed in portfolio and visit as improving

8.	Care in the last days of life	N/A as transition period from LCP to Priorities of Care.	All hospitals had developed their own personalised care plan for final days , in line with NICE Guidance and Five Priorities of care .

Part 2 In depth examples from GSF trained or accredited wards

1. Improving the Quality of Care

a. Culture

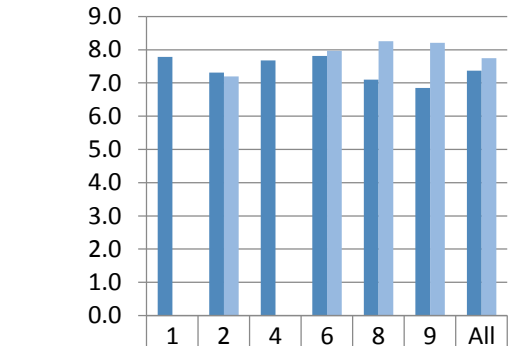
Key message: the culture of care is improved following GSF training .

Finding	***Evidence***
Improvements in the culture of care was recognised , moving from reactive responses to proactive anticipatory care planning, increasing patient centred care and involvement in decision making, and facilitating improved communication, team-working and collaboration. Patients, carers and staff benefit from cultural changes in perception of roles and responsibilities, a sense of working together and pride in giving quality care. The GSFAH programme enables staff to confidently raise discussions regarding individual needs, wishes and preferences, not just as a one off event, but more effectively as part of the culture of care they provide. Staff are enabled to support implementation of choices and communicate these preferences.	*"ADD HOSPITAL QUOTE HERE NOT PRIM CARE OR CARE HOMES PLEASE ~~GSF provided a vision of what end of life care can look like and the mechanism to deliver it. It is changing culture and practice in a really significant way. It's been transformational"~~* *~~(Dr Peter Nightingale Former RCGP EOL lead)~~* *~~"GSF has really pulled us all together as a team, both in the home and with our health and social care colleagues"~~* *~~(Care Home staff member)~~* "GSF has then given us the framework to engage with relatives and put things in place to ensure the outcome they want for their relative. The best bit is making sure that patients receive the care they want, where they want it, when and how they want it and the satisfaction they and we get from that." **- Dr Kumar, Consultant Geriatrician Royal Lancaster Infirmary** GSF helped us improve cross boundary communication - when the patient comes into hospital we know what their preferences are and we can explore if that is still the case, work with patients and families to ensure care is delivered to the gold standard of care they want and keep the patient in the driving seat" **Alison Scott, Lead nurse ELOC, Royal Lancaster**

Key message: GSF transforms staff confidence to manage the challenges in end of life care

b. Workforce confidence

The GSF AH programme increases staff confidence in caring for and recognising EoL patients. Following training staff rate a higher level of confidence in caring for people nearing the end of life.



	1	2	4	6	8	9	All
Baseline	7.8	7.3	7.7	7.8	7.1	6.8	7.4
Follow up		7.2		8.0	8.3	8.2	7.7

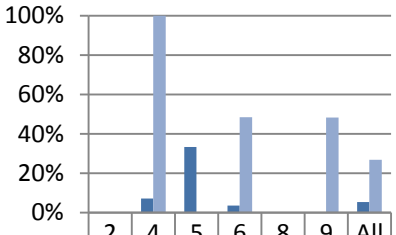
Mean of 'do I feel confident in caring for people nearing the end of life?' (*Staff rated scores on a scale of 1-10)*
Phase 3 GSFAH Staff questionnaire

GSFAH 3

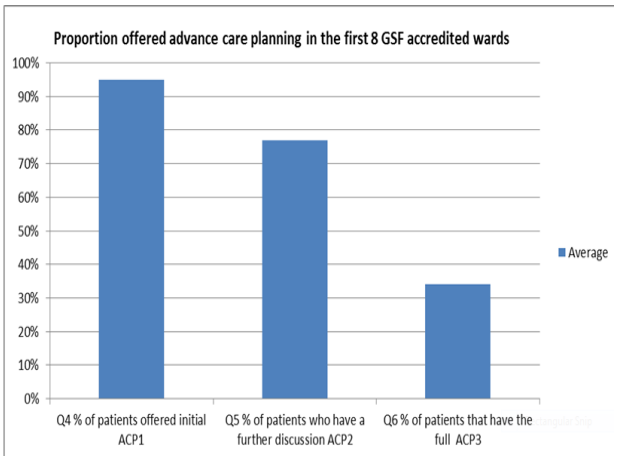
GSF facilitates ACP such that patients and carers receive care, support, information and symptom management in a timely and coordinated fashion.

c. Patient centred care

The **recording** of Passport Information (a patient held document with details about patients about patients wishes regarding care and preferences), significantly improves after GSF training. This important step of documenting patient wishes enable more patient centred care, ensuing patient goals are the focus of care.



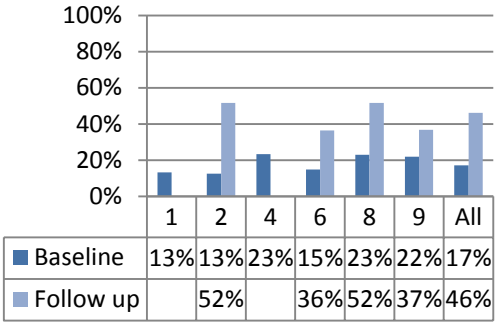
	2	4	5	6	8	9	All
baseline	0%	7%	33%	4%	0%	0%	5%
follow up	0%	100	0%	48%	0%	48%	27%

Evidence collated from the first 8 GSF accredited wards demonstrates the number of patients offered Advance Care panning. Column 1 shows the percentage offered initial discussion, column 2 shows the number of patients offered further discussion (to include DNACPR, preferred place of care and proxy spokesperson) and column 3 shows completion of full Advance Plan in line with locally approved documentation.	**Percentage of patients whose passport information was recorded on admission (all patients) *('yes' responses (other options NA, no, not recorded))*** GSFAH 3 

Key message: GSF enables people to live well until they die through proactive care planning and support

d. proactive and anticipatory planning

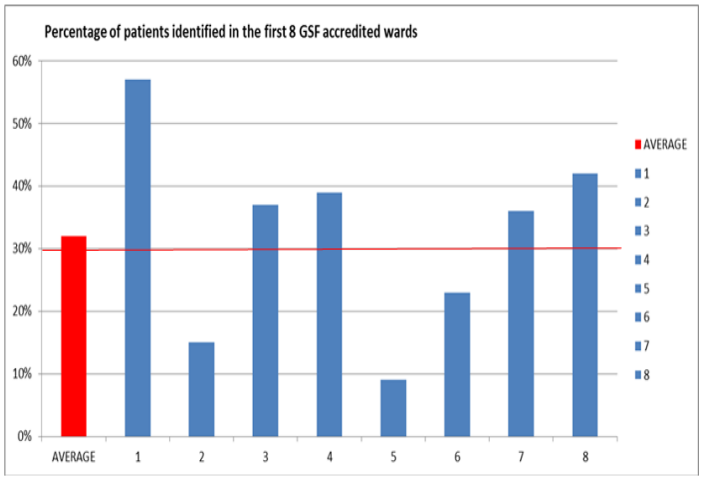
Implementation of GSF results in earlier recognition of more patients in last year of life, this facilitates proactive and anticipatory care.



Proportion of staff reporting using specific tools as a trigger to identify patients in the last year of life *(staff could respond 'yes have used', 'yes aware', or 'no')*

GSFAH 3

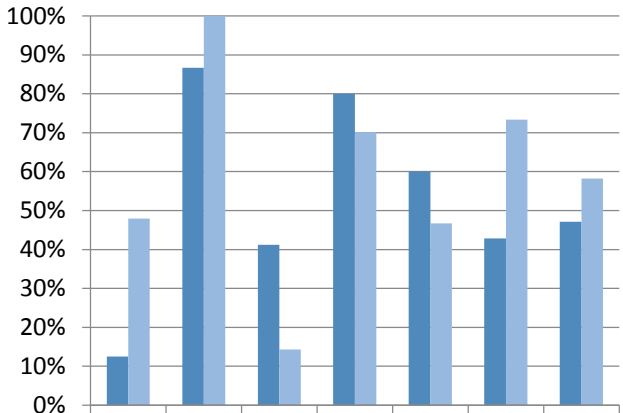
A snapshot showing the percentage of patients identified on rounds 1-3 of the accreditation process demonstrates that following AH GSF training wards are identifying 31% of patients potentially in the last year of life. This data correlates previous research (Clark, 2014). The variant numbers identified can be attributed to the ward settings which ranged from care of the elderly which shows higher numbers identified to acute renal identifying appropriately fewer patients.



The DNACPR is one aspect of anticipatory care, and involves discussion between patient and medical team.

Following GSF training an increasing percentage of patients are shown to have a Do Not Attempt to Resuscitate (DNAR)

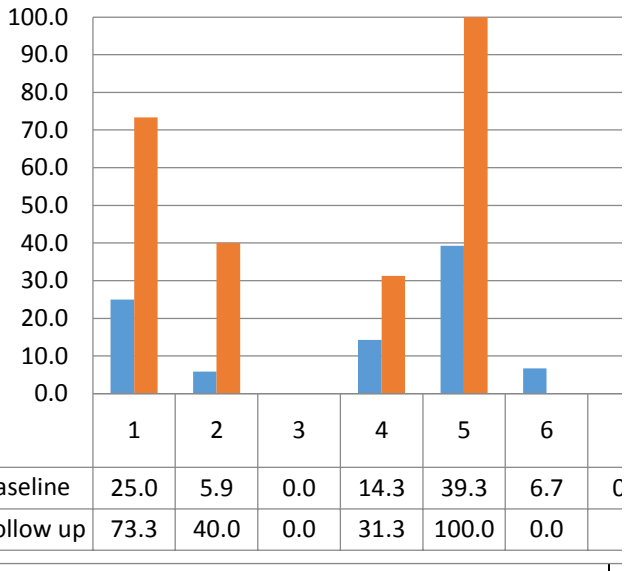
Percentage of patients for whom DNAR/NCR/AND was recorded, by hospital (patients who were discharged) *('yes' responses (other options NA, no, not recorded))*



	2	4	5	6	8	9	All
Baseline	13%	87%	41%	80%	60%	43%	47%
Follow up	48%	100%	14%	70%	47%	73%	58%

GSFAH 3

The number of patients for whom a preferred place of care is recorded increases following GSF training. By early identification of preferred place of care proactive planning can commence.



	1	2	3	4	5	6	
Baseline	25.0	5.9	0.0	14.3	39.3	6.7	0
Follow up	73.3	40.0	0.0	31.3	100.0	0.0	

Percentage of patients who died in hospital that had an ACP/PPC at baseline and follow up, by hospital

Key message: GSF reinforces robust governance through improving standards and accreditation.

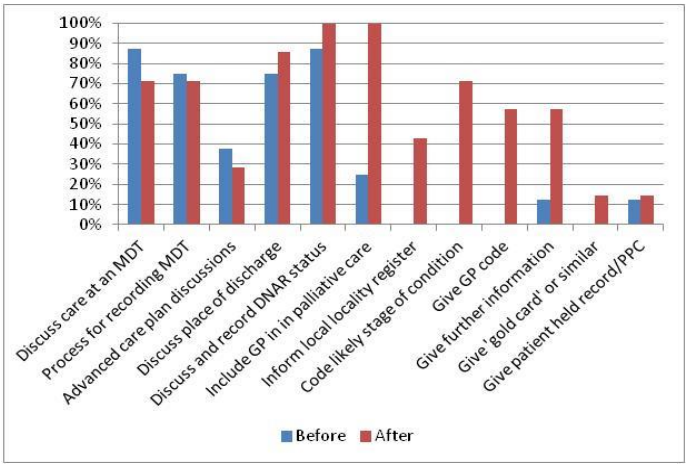
e. Standards and governance

Completing GSFAH helps hospitals meet CQUIN targets	*"The wards are doing really well with it and are meeting the CQUIN target. The CQUIN target was for 50% patients identified as GSF should have been identified on the discharge summary. GSF is discussed routinely on the ward round or MDT, it is a routine question for ward staff to ask if the patient is GSF and if so the ward are using the RAG coding to identify where they are, months, weeks, or days."* Phase 3 AFGSF Staff questionnaire
	Professor Sir Mike Richards, CQC's Chief Inspector of Hospitals, said: "*Royal Devon and Exeter NHS Foundation Trust is one of only three trusts in the country with recognition in achieving the Gold Standards Framework for end of life care, with three wards accredited and one deferred. Plans to extend the gold standard to further wards demonstrated an outstanding commitment by ward staff and the specialist palliative care team to end of life care*." http://www.cqc.org.uk/content/chief-inspector-hospitals-rates-royal-devon-and-exeter-nhs-foundation-trust-good

Coordination and collaboration

Key message: GSF improves coordination across care sectors and communication with patients and carers.

a. Coordination of care across boundaries

Cross boundary care and team working is enhanced through implementation of GSFAH training.	**Routine planning of further actions has increased** 

	GSFAH 2

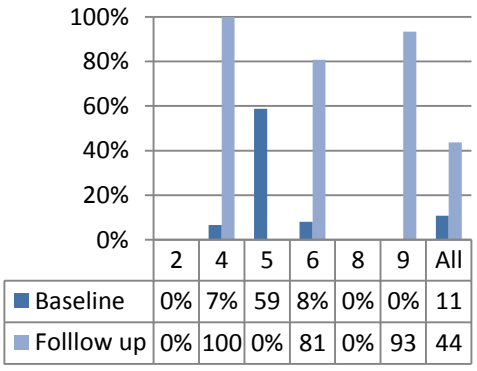
Key message: GSF empowers staff to work better with GPs and other health and social care professionals.

b. Collaboration and teamwork

Finding	Evidence
Implementation of GSF results in improved communication and coordination between those delivering EoL Care	*"Process on the ward involves putting a sticker in the notes for the medic so that the medic liaises with the GP and the ward nurse liaises with the DN on discharge."* *"Coordination with the other services that are out there for people using a common language"* "There is a shared understanding of what is meant by the coding system." "*The discharge summary has improved communication medic to GP and ward nurse to DN."* Phase 3 AFGSF Staff questionnaire

c. Communication between hospital and GP following patient discharge

Key message: GSF improves sharing of information between hospital and GP

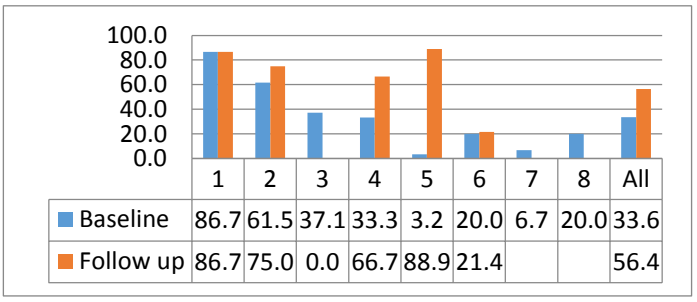
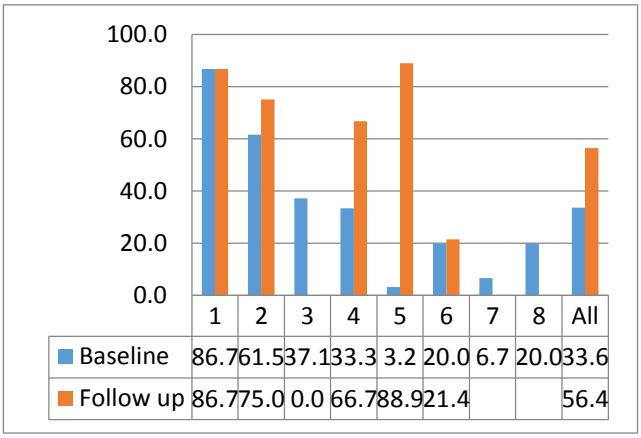
Improving coordination and collaboration by **sending out** Passport Information on patient discharge is found following GSF training	 **Percentage of patients who had passport information sent out**

	2	4	5	6	8	9	All
Baseline	0%	7%	59	8%	0%	0%	11
Folllow up	0%	100	0%	81	0%	93	44

	at baseline and follow up (discharged patients only) *('yes' responses (other options NA, no, not recorded))* GSFAH 3

d. Carers support

Key message: carers need are identified and assessed

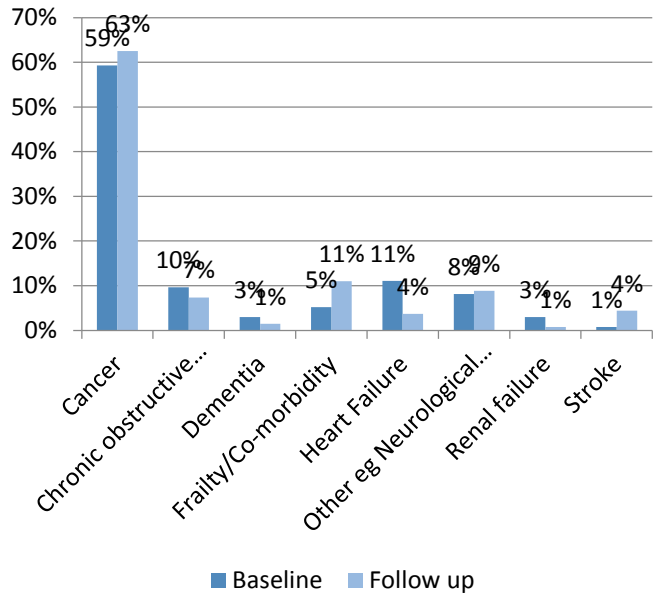
Data from the ADA demonstrates an increase in the number of discussions with carers with a 20% increase from baseline to follow up analysis.	**Change in percentage of discussions held with carers for discharged patients, by hospital**  **GSFAF 2**
Involvement of carers is recognised in EoL planning and communication with carers an important component of the Priorities for Care. GSF training increases the percentage of patients for whom a discussion with carers is held prior to patient discharge.	 **Change in percentage of discussions held with carers for discharged patients, by hospital** GSFAH 2

	1	2	3	4	5	6	7	8	All
Baseline	86.7	61.5	37.1	33.3	3.2	20.0	6.7	20.0	33.6
Follow up	86.7	75.0	0.0	66.7	88.9	21.4			56.4

Outcomes

a. Patient centred care

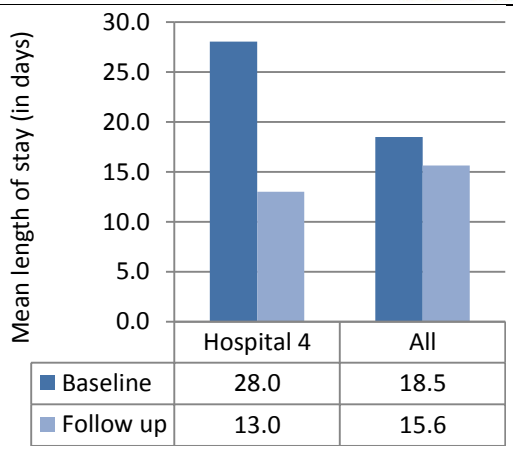
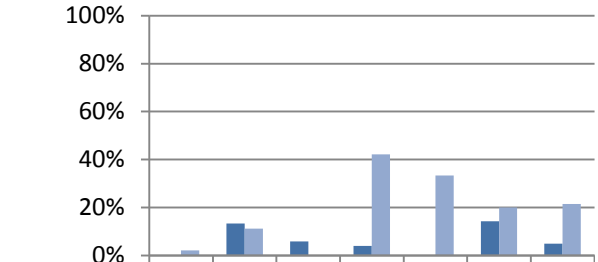
Key message: GSF facilitates identification of patients based on need rather than diagnosis, and enables people to live well until they die through proactive care planning and support

More patients are able to die in place of their choice following GSF training	**The impact of GSF on length of hospital stay and death in preferred place – results from the ADA audit** *"150 patients died at baseline, and 103 at follow-up. At baseline, only 3% of patients died in their preferred place; this rose to 12% at follow up. Additionally, only patients in hospitals 1 and 2 died in their preferred place at baseline, this good practice extended to hospitals 4 and 6 at follow up."* GSFAH 2
Use of GSF highlights patients reaching last year of life in conditions other than cancer. Frailty was seen to be the second main cause of death, and use of GSF facilitates EoL care planning across all life limiting conditions.	**Causes of death at baseline and follow up (all hospitals)**  GSF 3

Key message: GSF improves cost effectiveness and reduces costs to the NHS by reducing length of stay and facilitating rapid discharge in line with patient preferences.

b. Cost effectiveness

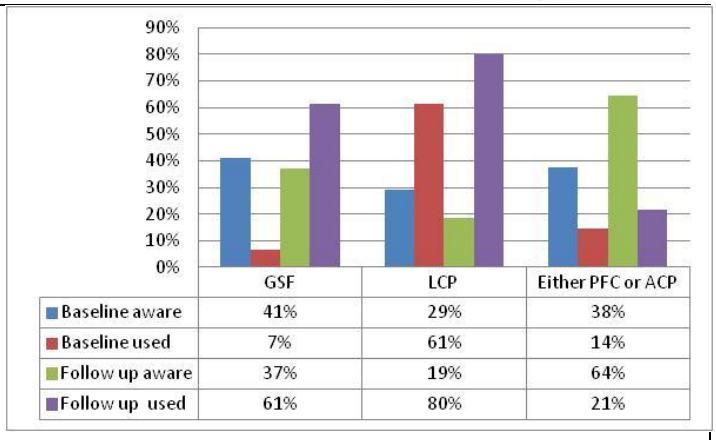
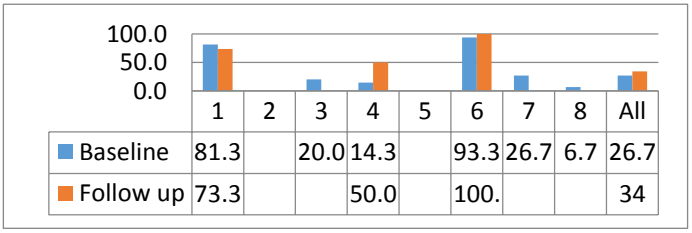
Patient length of hospital stay decreases following GSF training.	**Table 1.1 Average length of hospital stay at baseline and follow up, Hospital 4**

	 Hospital 4 / All Baseline: 28.0 / 18.5 Follow up: 13.0 / 15.6 GSFAH 3
The proportion of patients discharged on a rapid discharge pathway improves following GSF training.	**Percentage of patients on the rapid discharge pathway at baseline and follow up (patients discharged only) *('yes' responses (other options NA, no, not recorded))***  2 / 4 / 5 / 6 / 8 / 9 / All Baseline: 0% / 13% / 6% / 4% / 0% / 14% / 5% Follow up: 2% / 11% / 0% / 42% / 33% / 20% / 22% GSFAH 3

Key message: GSF facilitates clinically effective symptom assessment

Symptom control assessment

Following training staff demonstrate an improvement in knowledge and use of EoL care tools with follow up evaluation showing over 85% had either used or were aware of each of these tools. Since Phase 2 the LCP (Liverpool Care Pathway has been replaced with the Five Priorities for Care of the Dying Person)	**Staff experience of National EoL tools**

	 GSF / LCP / Either PFC or ACP Baseline aware: 41% / 29% / 38% Baseline used: 7% / 61% / 14% Follow up aware: 37% / 19% / 64% Follow up used: 61% / 80% / 21% **GSFAH 2**
An increase in the use of a symptom control assessment for both patients who die, and for those who are discharged indicates improved quality of patient care following GSF training .	**Change in percentage of patients who died in hospital who had an SCA used**  1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / All Baseline: 81.3 / 20.0 / 14.3 / 93.3 / 26.7 / 6.7 / 26.7 Follow up: 73.3 / 50.0 / 100. / 34 **GSFAH 2**

Key message: Hospitals can sustain and embed tangible ongoing good practice following GSF training

d. Sustainability

GSF training generates organisational change and ongoing improvements in coordination and collaboration. Organisations plan and develop EoL care actions following training.	*Increased advance care planning discussions at various levels* *Possible review of complaints to hospital and feedback from relatives using structured feedback tool (similar to VOICES or other questionnaires)* Example of recommendations, GSFAH 3
The impact of training encourages generalist staff to embed practice and continue	*"Routine 20 minute slots are scheduled on the ward to reflect back to ensure the ward staffs understanding of*

development and improvement.	*the process and then identify areas for further learning"* GSFAH 3 Staff questionnaire
The GSFAH programme results in ongoing service improvement for hospitals, with clear action plans and recommendations to facilitate further development.	Recommendations for future, GSF 3 *"Possible development with the CCGs of a contact help line for GSF registered patients to support patients nearing the end of life, where such support is not available from hospices or palliative care teams etc. (as developed in some areas)"*

Reference

Clark, D., Armstrong, M., Allan, A., Graham, F., Carnon, A. & Isles, C. 2014, "Imminence of death among hospital inpatients: Prevalent cohort study", *Palliative medicine,* vol. 28, no. 6, pp. 474-479.

Department of Health (2008) *End of Life Care Strategy*. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086345.pdf (Accessed 11 April 2016)

Department of Health (2014) *NHS outcomes framework 2015/16.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385749/NHS_Outcomes_Framework.pdf (Accessed 25 April 2016)

National Audit Office Report 2008. *End of Life Care*. London: HMSO

National Institute for Health and Clinical Excellence (2011). *Quality standard End of life care for adults* (2011). Available at: https://www.nice.org.uk/guidance/qs13/resources/end-of-life-care-for-adults-2098483631557 (Accessed 25 April 2016)

Royal College of Physicians (2016) *End of life care audit: dying in hospital - national report for England 2016*. Available at: https://www.rcplondon.ac.uk/projects/outputs/end-life-care-audit-dying-hospital-national-report-england-2016 (Accessed 11 April 2016)

National Palliative and End of Life Care Partnership (2015) *Ambitions for palliative and end of life care: A National Framework for Local Action 2015-2020.* Available at: http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf (Accessed 11 April 2016)

NHS England (2014) *Actions for End of Life Care: 2014 -16*. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf (Accessed 11 April 2016)

National Institute for Health and Clinical Excellence (2011). *Quality standard End of life care for adults* (2011). Available at: https://www.nice.org.uk/guidance/qs13/resources/end-of-life-care-for-adults-2098483631557 (Accessed 25 April 2016)

Publications

There are number of peer reviewed research publications which support the value of GSFAH programme implementation. A full review of literature from AMED, EMBASE, HMIC, BNI, Medline, PsycInfo, CINAHL, HEALTH BUSINESS ELITE; 3 [Limit to: Publication Year 2012-2016]; including terms "gold standards framework" AND "hospital" is available on the GSF website: http://www.goldstandardsframework.org.uk/evidence.

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